		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0031906

Facility Name: Genesis House

Address: 350 Sycamore Road (Number) Genoa (City) 60135 (Zip Code)

County: DeKalb

Telephone Number: (815) 784-5146 **Fax #** (815) 785-2594

IDPA ID Number: 363480754002

Date of Initial License for Current Owners: 12/07/1986

Type of Ownership:

	VOLUNTARY,NON-PROFIT			x	PROPRIETARY			GOVERNMENTAL
		Charitable Corp.			Individual			State
		Trust			Partnership			County
IRS Exemption Code					Corporation			Other
				x	"Sub-S" Corp.			
					Limited Liability Co.			
					Trust			
					Other			

In the event there are further questions about this report, please contact:
Name: Christine A. Hanover **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/01 to 06/30/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANTS' COMPILATION REPORT (Date)
	(Print Name and Title)	
	(Firm Name & Address)	Altschuler, Melvoin and Glasser LLP One South Wacker Drive, Suite 800, Chicago, IL 60606
	(Telephone)	(312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Genesis House # 0031906 Report Period Beginning: 07/01/01 Ending: 06/30/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds See attached schedule

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	92	Intermediate/DD	60	25,780	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	92	TOTALS	60	25,780	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	25,113			25,113	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,113			25,113	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.41%

D. How many bed-hold days during this year were paid by Public Aid?
318 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/07/86

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 12/07/86 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [x] If YES, enter number of beds certified _____ and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [x]

Tax Year: 12/31/02 Fiscal Year: 06/30/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Genesis House # 0031906 Report Period Beginning: 07/01/01 Ending: 06/30/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	121,507	13,243	8,313	143,063		143,063		143,063			1
2	Food Purchase		113,820		113,820		113,820	(17,434)	96,386			2
3	Housekeeping	95,034	23,243		118,277		118,277		118,277			3
4	Laundry	57,703	7,996		65,699		65,699		65,699			4
5	Heat and Other Utilities			47,282	47,282		47,282		47,282			5
6	Maintenance	42,049	10,048	31,157	83,254		83,254	1,979	85,233			6
7	Other (specify):*											7
8	**TOTAL General Services**	316,293	168,350	86,752	571,395		571,395	(15,455)	555,940			8
	B. Health Care and Programs											
9	Medical Director			28,404	28,404		28,404		28,404			9
10	Nursing and Medical Records	863,315	28,881	45,340	937,536		937,536		937,536			10
10a	Therapy			13,057	13,057		13,057		13,057			10a
11	Activities	83,494	1,227	840	85,561		85,561		85,561			11
12	Social Services	5,682			5,682		5,682		5,682			12
13	Nurse Aide Training	37,852	436		38,288		38,288		38,288			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	990,343	30,544	87,641	1,108,528		1,108,528		1,108,528			16
	C. General Administration											
17	Administrative	116,690			116,690		116,690		116,690			17
18	Directors Fees											18
19	Professional Services			124,803	124,803		124,803	1,691	126,494			19
20	Dues, Fees, Subscriptions & Promotions			9,294	9,294		9,294	(160)	9,134			20
21	Clerical & General Office Expenses	89,967	13,065	25,428	128,460		128,460	(832)	127,628			21
22	Employee Benefits & Payroll Taxes			183,203	183,203		183,203	17,434	200,637			22
23	Inservice Training & Education			5,980	5,980		5,980		5,980			23
24	Travel and Seminar			6,042	6,042		6,042		6,042			24
25	Other Admin. Staff Transportation			9,180	9,180		9,180		9,180			25
26	Insurance-Prop.Liab.Malpractice			28,043	28,043		28,043		28,043			26
27	Other (specify):*											27
28	**TOTAL General Administration**	206,657	13,065	391,973	611,695		611,695	18,133	629,828			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,513,293	211,959	566,366	2,291,618		2,291,618	2,678	2,294,296			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Genesis House #0031906 Report Period Beginning: 07/01/01 Ending: 06/30/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			34,927	34,927		34,927	3,484	38,411			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			65,131	65,131		65,131	(28,258)	36,873			32
33	Real Estate Taxes			19,009	19,009		19,009		19,009			33
34	Rent-Facility & Grounds			133,524	133,524		133,524	(52,798)	80,726			34
35	Rent-Equipment & Vehicles			59,829	59,829		59,829		59,829			35
36	Other (specify):*											36
37	**TOTAL Ownership**			312,420	312,420		312,420	(77,572)	234,848			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			3,500	3,500		3,500		3,500			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			198,899	198,899		198,899		198,899			42
43	Other (specify):* **Nonallowable Costs**			791,923	791,923		791,923	(791,923)				43
44	**TOTAL Special Cost Centers**			994,322	994,322		994,322	(791,923)	202,399			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,513,293	211,959	1,873,108	3,598,360		3,598,360	(866,817)	2,731,543			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Genesis House # 0031906 Report Period Beginning: 07/01/01 Ending: 06/30/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,385	30		9
10	Interest and Other Investment Income	(41,632)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(818)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(160)	20		17
18	Fines and Penalties	(2,500)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(9,442)	43		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached Sch 5A	(778,047)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (831,214)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(35,603)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (35,603)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (866,817)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Genesis House

ID# 0031906

Report Period Beginning: 07/01/01

Ending: 06/30/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Genesis House # 0031906 **Report Period Beginning:** 07/01/01 **Ending:** 06/30/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,691	0	0	0	0	0	0	0	0	0	1,691	19
20	Fees, Subscriptions & Promotions	(160)	0	0	0	0	0	0	0	0	0	0	(160)	20
21	Clerical & General Office Expenses	0	31	0	0	0	0	0	0	0	0	0	31	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(160)	1,722	0	0	0	0	0	0	0	0	0	1,562	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(160)	1,722	0	0	0	0	0	0	0	0	0	1,562	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Genesis House # 0031906 **Report Period Beginning:** 07/01/01 **Ending:** 06/30/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	1,385	2,099	0	0	0	0	0	0	0	0	0	3,484	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(41,632)	13,374	0	0	0	0	0	0	0	0	0	(28,258)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(52,798)	0	0	0	0	0	0	0	0	0	(52,798)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(40,247)	(37,325)	0	0	0	0	0	0	0	0	0	(77,572)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(12,760)	0	0	0	0	0	0	0	0	0	0	(12,760)	43
44	**TOTAL Special Cost Centers**	(12,760)	0	0	0	0	0	0	0	0	0	0	(12,760)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(53,167)	(35,603)	0	0	0	0	0	0	0	0	0	(88,770)	45

Facility Name & ID Number Genesis House # 0031906 Report Period Beginning: 07/01/01 Ending: 06/30/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Catherine Bachand	100.00			Ma Retraite LLC	Genoa	Real Estate Holding
				Avancer LLC	Genoa	CILA Operations
				Ma Maison LLC	Genoa	CILA Real Estate

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Professional Fees	$	Ma Retraite LLC	100.00%	$ 1,691	$ 1,691	1
2	V	30	Depreciation		Ma Retraite LLC	100.00%	2,099	2,099	2
3	V	32	Interest		Ma Retraite LLC	100.00%	13,374	13,374	3
4	V	34	Rent - Facility & Grounds		Ma Retraite LLC	100.00%	(52,798)	(52,798)	4
5	V	21	Office Supplies		Ma Retraite LLC	100.00%	31	31	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$ (35,603)	$ * (35,603)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Genesis House # 0031906 Report Period Beginning: 07/01/01 Ending: 06/30/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Catherine A. Bachand	Administrator	Administration	100.00	None	36	75.00	Salary	$ 116,690	L17, C1	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 116,690		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Genesis House # 0031906 Report Period Beginning: 07/01/01 Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [x]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5	N/A									5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Genesis House # 0031906 Report Period Beginning: 07/01/01 Ending: 06/30/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Advance Leasing Corp		x	Heating and cooling system	$803.00	9/99	$ 33,201	$ 17,587	9/04	0.1573	$ 3,636	1
2	ABB Business Finance		x	Telephone system	$394.00	12/01	16,957	15,740	12/06	0.1396	1,148	2
3	GreatAmerica Leasing		x	Time clock	$338.00	3/02	9,217	8,429	3/05	0.1902	564	3
4	Resource Bank		x	Mortgage	$11,250.00	2/02	450,000	426,917	3/12	Prime	13,374	4
5												5
	Working Capital											
6	Resource Bank		x	Working capital	N/A	4/02	Various	545,978	4/03	0.1140	46,591	6
7	Healthcare Business		x	Working capital	N/A	Various	Various			LIBOR	13,192	7
8												8
9	TOTAL Facility Related				$12,785.00		$ 509,375	$ 1,014,651			$ 78,505	9
	B. Non-Facility Related*											
10												10
11	Interest income offset										(41,632)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (41,632)	14
15	TOTALS (line 9+line14)						$ 509,375	$ 1,014,651			$ 36,873	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ -0- Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Genesis House # 0031906 Report Period Beginning: 07/01/01 Ending: 06/30/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		$ 18,553	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2001	$ 18,408	2
3. Under or (over) accrual (line 2 minus line 1).		$ (145)	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 19,154	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 19,009	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	21,954	8
	1998	22,319	9
	1999	24,227	10
	2000	17,406	11
	2001	18,708	12

2nd installment of 2000 -	9,354	Real Estate Taxes paid include:	
1/2 of 2001 taxes w/3% increase	9,800	2001 taxes	9,052
		2002 taxes	9,354
2002 Accrual	19,154	Total	18,408

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Genesis House COUNTY DeKalb

FACILITY IDPH LICENSE NUMBER 0031906

CONTACT PERSON REGARDING THIS REPORT Christine A. Hanover

TELEPHONE (312) 634-4581 FAX #: (312) 634-5518

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200l

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	03-29-152-010	350 Sycamore Road, Genoa, IL	$ 18,708.00	$ 18,708.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 18,708.00	$ 18,708.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES x NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Genesis House # 0031906 Report Period Beginning: 07/01/01 Ending: 06/30/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 19,500 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (b) Rent from a Related Organization. [x] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident care	92,000	2002	$ 122,310	1
2					2
3	TOTALS	92,000		$ 122,310	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Genesis House # 0031906 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	60		2002	1972	$ 440,888	$ 2,099	35	$ 2,099	$	$ 2,099	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Leasehold improvements			1988	572		15	38	38	551	9
10	Roof			1992	34,891		15	2,326	2,326	24,423	10
11	Plumbing			1991	1,594		5			1,594	11
12	Office furniture partitions			1992	4,192	419	15	280	(139)	2,660	12
13	Office furniture partitions			1993	1,302	130	15	87	(43)	827	13
14	Landscaping			1993	13,295	1,329	15	886	(443)	8,417	14
15	tile			1993	5,177		15	345	345	3,278	15
16	Dry wall			1993	2,500		15	167	167	1,586	16
17	Building repair			1994	1,485		30	49	49	369	17
18	Alarm System			1994	5,391		30	180	180	1,350	18
19	Road paving			1994	36,015		30	1,201	1,201	9,007	19
20	Window and door replacement			1994	27,934		30	931	931	6,983	20
21	Parking lot repair			1994	796		30	27	27	202	21
22	Heating and air conditioning			1994	15,850		30	528	528	3,959	22
23	Parking lot sidewalk repair			1995	64,241		30	2,141	2,141	13,917	23
24	Plumbing, heating, electrical, carpeting			1996	12,760		30	425	425	2,338	24
25	Building repair - new windows			1997	9,930	993	25	397	(596)	1,787	25
26	Building repair to kitchen			1998	4,137	413	25	165	(248)	743	26
27	Bathroom repairs			1998	11,990		25	480	480	1,680	27
28	Windows			1999	34,053	905	15	2,271	1,366	5,677	28
29	Shower Door			1999	690	69	10	69		173	29
30	HVAC Units			1999	77,202	5,610	15	5,147	(463)	12,867	30
31	Sealcoating			2002	2,108	105	15	70	(35)	70	31
32	Non-facility Depreciation					5,000			(5,000)		32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Genesis House # 0031906 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 808,993	$ 17,072		$ 20,309	$ 3,237	$ 106,557	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Genesis House # 0031906 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 106,380	$ 17,200	$ 15,348	$ (1,852)	5-10	$ 53,730	71
72	Current Year Purchases	27,538	2,754	2,754		5	2,754	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 133,918	$ 19,954	$ 18,102	$ (1,852)		$ 56,484	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Care	1985 Ford Van	1987	$ 13,039	$	$	$		$ 13,039	76
77	Administrative	1996 Ford Escort	1995	14,431					14,431	77
78										78
79										79
80	TOTALS			$ 27,470	$	$	$		$ 27,470	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,092,691	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 37,026	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 38,411	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 1,385	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 190,511	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Genesis House # 0031906 Report Period Beginning: 07/01/01 Ending: 06/30/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Roskamp Brothers - thru 2/2002

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1972	92	12/7/86	$ 80,726	15	N/A	3
4	Additions							4
5								5
6								6
7	TOTAL		92		$ 80,726 **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized by the length of the lease N/A . N/A

9. Option to Buy: ☐ YES ☐ NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning 12/7/86
Ending 12/7/01

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 13,851 Description: Fax - $2,590, Copier - $10,113, Postage Meter - $1,148
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Resident care	Vans	$ 2115	$ 28,515	17
18	Administrative	2001 Lexus	1455	17,463	18
19					19
20					20
21	TOTAL		$	$ 45,978	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Genesis House # 0031906 Report Period Beginning: 07/01/01 Ending: 06/30/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [x] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [x]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 42

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [x]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 80

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		436		436
3	Classroom Wages (a)		19,720		19,720
4	Clinical Wages (b)		10,030		10,030
5	In-House Trainer Wages (c)		8,102		8,102
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 38,288	$	$ 38,288
10	SUM OF line 9, col. 1 and 2 (e)	$ 38,288			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$ 39,740

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	29
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	29

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care	L 39, C 3	visits		35	2,100		35	2,100	5
6	Dental Care	L 39, C 3	visits		23	1,400		23	1,400	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	58	$ 3,500	$	58	$ 3,500	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Genesis House
Provider #: 0031906
07/01/01 to 06/30/02

Schedule 16A

XIV. Special Services
Line 13 Other (specify):

Service	Line Reference	Outside Practioner Units	Cost	Supplies
	L39, C3			
	L39, C3			
	L39, C3			
	L39, C3			
Total			0	0

See Accountants' Compilation Report

Facility Name & ID Number Genesis House # 0031906 Report Period Beginning: 07/01/01 Ending: 06/30/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 198,195	$ 223,827	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 10,000)	873,850	873,850	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	18,851	18,851	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	324,502	224,690	8
9	Other(specify): Due from Shareholder	549,137	549,137	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,964,535	$ 1,890,355	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		122,310	13
14	Buildings, at Historical Cost		440,888	14
15	Leasehold Improvements, at Historical Cost	150,808	368,105	15
16	Equipment, at Historical Cost	140,147	161,388	16
17	Accumulated Depreciation (book methods)	(126,906)	(190,511)	17
18	Deferred Charges		988	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (sp Deposits	5,803	5,803	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 169,852	$ 908,971	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,134,387	$ 2,799,326	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 64,346	$ 64,346	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	558,739	558,739	29
30	Accrued Salaries Payable	78,877	78,877	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	27,554	19,154	32
33	Accrued Interest Payable		2,739	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses		21,660	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 729,516	$ 745,515	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	28,996	28,996	39
40	Mortgage Payable		426,916	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 28,996	$ 455,912	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 758,512	$ 1,201,427	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,375,875	$ 1,597,899	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,134,387	$ 2,799,326	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Genesis House # 0031906 Report Period Beginning: 07/01/01 Ending: 06/30/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,172,068	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,172,068	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	653,807	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(450,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 203,807	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,375,875	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Genesis House # 0031906 Report Period Beginning: 07/01/01 Ending: 06/30/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,162,945	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,162,945	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	39,740	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	2,152	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 41,892	23
	D. Non-Operating Revenue		
24	Contributions	100	24
25	Interest and Other Investment Income***	41,632	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 41,732	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**See attached schedule 19A**	5,598	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,598	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,252,167	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	571,395	31
32	Health Care	1,108,528	32
33	General Administration	611,695	33
	B. Capital Expense		
34	Ownership	312,420	34
	C. Ancillary Expense		
35	Special Cost Centers	795,423	35
36	Provider Participation Fee	198,899	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,598,360	40
41	**Income before Income Taxes (line 30 minus line 40)****	653,807	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 653,807	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. Federal Income Tax Return is filed using cash basis on a calendar year.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Genesis House # 0031906 Report Period Beginning: 07/01/01 Ending: 06/30/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,790	2,854	$ 75,801	$ 26.56	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,013	2,198	45,924	20.89	3
4	Licensed Practical Nurses	2,553	2,621	54,383	20.75	4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees	3,538	3,538	29,750	8.41	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,746	1,828	23,378	12.79	9
10	Activity Assistants	5,941	6,200	60,116	9.70	10
11	Social Service Workers	190	206	5,682	27.58	11
12	Dietician	2,018	2,146	34,136	15.91	12
13	Food Service Supervisor					13
14	Head Cook	4,691	4,880	36,140	7.41	14
15	Cook Helpers/Assistants	7,374	7,480	51,231	6.85	15
16	Dishwashers					16
17	Maintenance Workers	4,426	4,636	42,049	9.07	17
18	Housekeepers	12,417	12,807	95,034	7.42	18
19	Laundry	6,969	7,328	57,703	7.87	19
20	Administrator	1,950	1,950	116,690	59.84	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,059	6,398	89,967	14.06	24
25	Vocational Instruction					25
26	Academic Instruction	548	573	8,102	14.14	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	6,509	6,810	100,000	14.68	28
29	Resident Services Coordinator	1,866	2,091	40,992	19.60	29
30	Habilitation Aides (DD Homes)	50,753	52,044	536,580	10.31	30
31	Medical Records	842	872	9,635	11.05	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	125,193	129,460	$ 1,513,293 *	$ 11.69	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	71	$ 8,313	L1, C3	35
36	Medical Director	Monthly	28,404	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,800	L10, C3	39
40	Physical Therapy Consultant	238	10,706	L10A, C3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	43	2,351	L10A, C3	43
44	Activity Consultant	14	840	L11, C3	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Psychiatric Consultant	10	1,900	L10, C3	47
48	Psychologist Consultant	77	5,813	L10, C3	48
49	TOTAL (lines 35 - 48)	453	$ 60,127		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	34	$ 1,351	L10, C3	50
51	Licensed Practical Nurses				51
52	Nurse Aides	1,033	34,476	L10, C3	52
53	TOTAL (lines 50 - 52)	1,067	$ 35,827		53

Facility Name & ID Number Genesis House # 0031906 Report Period Beginning: 07/01/01 Ending: 06/30/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Catherine A. Bachand	Administrato	100	$ 116,690
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 116,690

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
American Express Tax & Business	Accounting	$ 19,469
Altschuler Melvoin & Glasser	Accounting	10,187
Resource Bank	Loan Fees	900
Piper Rudnick	Legal	75,643
Shefsky & Froelick Ltd	Legal	284
3D Computer Sales	Computer Services	1,059
Health Data Systems	Computer Services	6,592
United Info Systems	Computer Services	2,418
Info Controls	Computer Services	1,711
ADP	Payroll Service	6,270
Great America Leasing	Loan Fees	270
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 124,803

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 13,570
Unemployment Compensation Insurance	13,767
FICA Taxes	115,767
Employee Health Insurance	36,616
Employee Meals	17,434
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	3,483
TOTAL (agree to Schedule V, line 22, col.8)	$ 200,637

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	6,337
Health Care Worker Background Check	1,514
(Indicate # of checks performed 126)	
Licenses and permits	610
Dues and subscriptions	673
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,134

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	6,042
See attached schedule	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,042

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Genesis House
Provider #: 0031906
07/01/01 to 06/30/02

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3)	124,803
Allocated from Management Company	
Total (agree to Schedule V, line 19, column 8)	124,803

See Accountants' Compilation Report

Facility Name & ID Number Genesis House # 0031906 Report Period Beginning: 07/01/01 Ending: 06/30/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	Repairs to refrigeration	9/99	$ 2,936	3	$	$ 489	$ 979	$ 979	$ 489	$	$	$	$
2	Electrical work	10/99	2,999	3		500	1,000	1,000	499				
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 5,935		$	$ 989	$ 1,979	$ 1,979	$ 988	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Genesis House # 0031906 **Report Period Beginning:** 07/01/01 **Ending:** 06/30/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5.0**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **7,244** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **x** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **198,899**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **17,434** Has any meal income been offset against
related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? Yes
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT **Genesis House** **02:54 PM** **11/04/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-866,817	equal to	-866,817	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	36,873	equal to	36,873	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	19,009	equal to	19,009	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	38,411	equal to	38,411	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	80,726	equal to	80,726	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	59,829	equal to	59,829	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	38,288	equal to	38,288	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	13,057	equal to	13,057	0	O.K.	Pg16 Z12+Z14...	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies		equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	571,395	equal to	571,395	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,108,528	equal to	1,108,528	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	611,695	equal to	611,695	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	312,420	equal to	312,420	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	795,423	equal to	795,423	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	198,899	equal to	198,899	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	871,417	equal to	863,315	8,102	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	29,750	< or = to	37,852	-8,102	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	83,494	equal to	83,494	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	5,682	equal to	5,682	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	121,507	equal to	121,507	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	42,049	equal to	42,049	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	95,034	equal to	95,034	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	57,703	equal to	57,703	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	116,690	equal to	116,690	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	89,967	equal to	89,967	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	1,513,293	equal to	1,513,293	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	8,313	< or = to	8,313	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	28,404	< or = to	28,404	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	45,340	< or = to	45,340	0	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	840	< or = to	840	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to		0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	116,690	equal to	116,690	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other		equal to		0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	124,803	equal to	124,803	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	200,637	equal to	200,637	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	9,134	equal to	9,134	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	6,042	equal to	6,042	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	198,899	equal to	198,899	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	17,434	< or = to	17,434	0	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	17,434	equal to	17,434	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	37,852	equal to	37,852	0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	N/A	equal to	0	#VALUE!	#VALUE!	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-35,603	equal to	-35,603	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	1,014,651	equal to	1,014,651	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	19,154	equal to	19,154	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	122,310	equal to	122,310	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	808,993	equal to	808,993	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	161,388	equal to	161,388	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	190,511	equal to	190,511	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	1,375,875	equal to	1,375,875	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	653,807	equal to	653,807	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	988	equal to	988	0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	2,134,387	equal to	2,134,387	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustmen	Adjusted Total
1. Dietary	121,507	13,243	8,313	143,063	0	143,063	0	143,063
2. Food P	0	113,820	0	113,820	0	113,820	-17,434	96,386
3. Housek	95,034	23,243	0	118,277	0	118,277	0	118,277
4. Laundry	57,703	7,996	0	65,699	0	65,699	0	65,699
5. Heat ar	0	0	47,282	47,282	0	47,282	0	47,282
6. Mainter	42,049	10,048	31,157	83,254	0	83,254	1,979	85,233
7. Other (s	0	0	0	0	0	0	0	0
8. Total G	316,293	168,350	86,752	571,395	0	571,395	-15,455	555,940
9. Medical	0	0	28,404	28,404	0	28,404	0	28,404
10. Nursin	863,315	28,881	45,340	937,536	0	937,536	0	937,536
10a. Ther	0	0	13,057	13,057	0	13,057	0	13,057
11. Activit	83,494	1,227	840	85,561	0	85,561	0	85,561
12. Social	5,682	0	0	5,682	0	5,682	0	5,682
13. Nurse	37,852	436	0	38,288	0	38,288	0	38,288
14. Progra	0	0	0	0	0	0	0	0
15. Other	0	0	0	0	0	0	0	0
16. Total H	990,343	30,544	87,641	1,108,528	0	1,108,528	0	1,108,528
17. Admin	116,690	0	0	116,690	0	116,690	0	116,690
18. Direct	0	0	0	0	0	0	0	0
19. Profes	0	0	124,803	124,803	0	124,803	1,691	126,494
20. Fees,	0	0	9,294	9,294	0	9,294	-160	9,134
21. Clerica	89,967	13,065	25,428	128,460	0	128,460	-832	127,628
22. Emplo	0	0	183,203	183,203	0	183,203	17,434	200,637
23. Inserv	0	0	5,980	5,980	0	5,980	0	5,980
24. Travel	0	0	6,042	6,042	0	6,042	0	6,042
25. Other	0	0	9,180	9,180	0	9,180	0	9,180
26. Insura	0	0	28,043	28,043	0	28,043	0	28,043
27. Other	0	0	0	0	0	0	0	0
28. Total (	206,657	13,065	391,973	611,695	0	611,695	18,133	629,828
29. Total (	1,513,293	211,959	566,366	2,291,618	0	2,291,618	2,678	2,294,296
30. Depre	0	0	34,927	34,927	0	34,927	3,484	38,411
31. Amorti	0	0	0	0	0	0	0	0
32. Interes	0	0	65,131	65,131	0	65,131	-28,258	36,873
33. Real E	0	0	19,009	19,009	0	19,009	0	19,009
34. Rent -	0	0	133,524	133,524	0	133,524	-52,798	80,726
35. Rent -	0	0	59,829	59,829	0	59,829	0	59,829
36. Other	0	0	0	0	0	0	0	0
37. Total (	0	0	312,420	312,420	0	312,420	-77,572	234,848
38. Medica	0	0	0	0	0	0	0	0
39. Ancilla	0	0	3,500	3,500	0	3,500	0	3,500
40. Barbe	0	0	0	0	0	0	0	0
41. Coffee	0	0	0	0	0	0	0	0
42. Provid	0	0	198,899	198,899	0	198,899	0	198,899
43. Other	0	0	791,923	791,923	0	791,923	-791,923	0
44. Total S	0	0	994,322	994,322	0	994,322	-791,923	202,399
45. Grand	1,513,293	211,959	1,873,108	3,598,360	0	3,598,360	-866,817	2,731,543

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in ba	198,195	223,827
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recie	873,850	873,850
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	18,851	18,851
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Ov	324,502	224,690
9. Other (specify):	549,137	549,137
10. Total current assets	1,964,535	1,890,355
LONG TERM ASSETS		
11. Long-Term Notes Rece	0	0
12. Long-Term Investments	0	0
13. Land	0	122,310
14. Buildings, at Historical	0	440,888
15. Leasehold Improvemer	150,808	368,105
16. Equipment, at Historica	140,147	161,388
17. Accumulated Depreciat	-126,906	-190,511
18. Deferred Charges	0	988
19. Organization & Pre-Op	0	0
20. Accum Amort - Org/Pre	0	0
21. Restricted Funds	0	0
22. Other Long-Term Asse	5,803	5,803
23. other (specify):	0	0
24. Total Long-Term Asset	169,852	908,971
25. Total Assets	2,134,387	2,799,326
CURRENT LIABILITIES		
26. Accounts Payable	64,346	64,346
27. Officer's Accounts Paya	0	0
28. Accounts Payable-Patie	0	0
29. Short-Term Notes Paya	558,739	558,739
30. Accrued Salaries Paya	78,877	78,877
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Ta	27,554	19,154
33. Accrued Interest Payab	0	2,739
34. Deferred Compensatior	0	0
35. Federal and State Inco	0	0
36. Other Current Liabilities	0	21,660
37. Other Current Liabilities	0	0
38. Total Current Liabilities	729,516	745,515
LONG TERM LIABILITES		
39.Long-Term Notes Payal	28,996	28,996
40.Mortgage Payable	0	426,916
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabili	0	0
44.Other Long-Term Liabili	0	0
45.Total Long-Term Liabilit	28,996	455,912
46.Total Liabilities	758,512	1,201,427
47.Total Equity	1,375,876	1,597,899
48.Total Liabilities and Equ	2,134,388	2,799,326

	Balance per Medicaid Trial Balance	
1. Gross Revenue - All levels of Care		4,162,945
2. Discounts and Allowances for all Levels		0
Subtotal - Inpatient Care		4,162,945
4. Day Care		0
5. Other Care for Outpatients		0
6. Therapy		0
7. Oxygen		0
Subtotal - Anciliary Revenue	-	
9. Payments for Education		0
10. Other Governmental Grants		0
11. Nurses Aide Training Reimbursements		39,740
12. Gift and Coffee Shop		0
13. Barber and Beauty Care		0
14. Non-Patient Meals		0
15. Telephone, Television, and Radio		0
16. Rental of Facility Space		0
17. Sale of Drugs		0
18. Sale of Supplies to Non-Patients		0
19. Laboratory		0
20. Radiologyand X-Ray		0
21. Other Medical Services		2,152
22. Laundry		0
Subtotal - Other Operating Revenue		41,892
24. Contributions		100
25. Interest and Other Investments Income		41,632
Subtotal - Non-Operating Revenue		41,732
27. Other Revenue (specify):		5,598
28. Other Revenue (specify):		0
Subtotal - Other Revenue		5,598
30. Total Revenue		4,252,167
31. General Services		571,395
32. Health Care		1,108,528
33. General Administration		611,695
34. Ownership		312,420
35. Special Cost Centers		795,423
35. Provider Participation Fee		198,899
37. Other		0
40. Total Expenses		3,598,360
41. Income Before Income Taxes		653,807
42. Income Taxes		0
43. Net Income or Loss for the Year		653,807

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Line 16 for mortgage insurance.